The Hampden Hippocrat

JANUARY
1978

Discussing the "National Commission on the Cost of Medical Care"; left to right, H. Thomas Ballantine, M.D. Member of Board of Trustees of the AMA, John C. Ayres, M.D. Alternate Delegate to the AMA and Donald R. Hayes, M.D. Member of the Commission. Picture taken at the Interim Meeting of the AMA in Chicago, December 7, 1977 by Joe Fletcher, AMA photographer.

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JANUARY - 1978 VOL. XXXIV-NO. 1

THE HAMPDEN HIPPOCRAT
·1942·

The official bulletin
for The Hampden District
of The Massachusetts
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William A. R. Chapin, M.D.

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THE HAMPDEN HIPPOCRAT IS PUBLISHED MONTHLY EXCEPT FOR JULY AND AUGUST.
THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.
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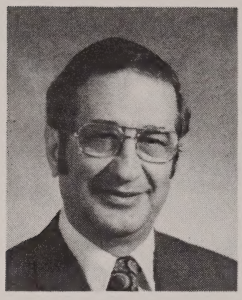

PRESIDENT'S PAGE

"THE PROBLEM"

A perplexing problem for our profession is the impaired physician. The American Medical Association has stated that between six to eight percent of our colleagues are impaired due to alcoholism, drugs, and illness: mental or physical.

The problem is complicated further not only by suspicion that a colleague is impaired, but by lack of adequate, effective mechanisms for help and rehabilitation.

Last February the Chairman of the Peer Review Committee of The Hampden District Medical Society spent three days in Augusta, Georgia. He attended the AMA sponsored national meeting on The Impaired Physician. Our colleague learned that over two-thirds of The State Medical Societies in this nation have engaged in serious efforts to promote effective physician-sponsored programs. The programs vary from state to state but the principles remain the same: detection, help, rehabilitation. The degree of success varies but is in proportion to the degree of involvement by physician organizations.

Last spring the HDMS sent a resolution to the Massachusetts Medical Society stating that a state-sponsored program of help for the impaired physician should be instituted.

The Massachusetts Medical Society so far has been slow to act. Time is running out. We may be the last of the 50 state societies to institute a program. Or we may be THE ONLY ONE without a program.

The forthcoming quarterly meeting of the HDMS will have as guest speakers a representative from the Americal Medical Association and a representative from the Ohio State Medical Society who will speak to us on the problem. Ohio has been one of the most successful of the state medical societies to institute a program which is effective in detection, help, and rehabilitation of the impaired physician.

Let us heed, help, and habilitate. □

ROCCO A. VERRILLI, M.D.

BAYPAC NEEDS YOU!

The Hampden District Medical Society members will receive, along with their Massachusetts Medical Society bills for 1978, an envelope to contribute for membership in BAYPAC and AMPAC. These organizations are not frozen food processors or government transportation organizations!

The BAY STATE Physicians Political Action Committee and the American Medical Association Political Action Committee need your support for this coming crucial election year on the national and state levels to have an effective voice in the important legislative actions and deliberations on the near horizon. Thoughtful, reasonable people need to be supported for election and re-election in order to give us a genuine hearing on all political levels.

This effort needs your money, your voice, and your active cooperation, because the "tomorrows" we have been hearing about are now "todays", and will be "yesterdays" one and two years from now.

This is the challenge; this is seen by any of us to be the last opportunity before the legislative verdicts begin to come in. Please respond - for your patients and for yourselves!

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(1) WHAT IS BAYPAC?
The Bay State Physicians Political Action Committee is a voluntary, non-profit, unincorporated group whose membership consists of physicians, their wives, the members of their immediate family, and others.

(2) WHY WAS BAYPAC ORGANIZED?
To meet an unmet need -- the need of providing the medical profession with an opportunity to assume a more active and effective role in public affairs. BAYPAC's dual role is (a) to help its members understand political issues; and (b) to organize them as an effective political action group.

(3) IS BAYPAC AFFILIATED WITH EITHER MAJOR POLITICAL PARTY?
No. It is not bound by Democratic or Republican party labels. The program and platform of the individual candidate will determine whom BAYPAC supports -- **not** the candidate's party afffiliation.

(4) WHO DIRECTS BAYPAC's ACTIVITIES?
BAYPAC's Board of Directors, made up of not more than 35 members, at least one of whom is a member of the Woman's Auxiliary to the Massachusetts Medical Society, and at least three-fourths of whom shall be Doctors of Medicine. No director shall serve for more than five years.

(5) IS BAYPAC A PERMANENT ORGANIZATION?
Yes. The impetus for BAYPAC came from physicians and others who wished to expand their knowledge of government and their activities in the field of political action. BAYPAC's members are profoundly interested in making their organization an effective, year-in-and-year-out operation. Experience has demonstrated beyond argument that one-shot, one-issue membership programs for political education and action accomplish little; and that political effectiveness depends upon a knowledge by the individual and group of current issues, and continuity of their participation in political affairs.

(6) WHAT IS THE RELATIONSHIP BETWEEN BAYPAC AND THE MASSACHUSETTS MEDICAL SOCIETY?
BAYPAC will function independently of all medical organizations and societies -- national, state, and local. However, the directors of BAYPAC are appointed yearly by the Executive Committee of the Massachusetts Medical Society. Further, the Massachusetts Medical Society and other incorporated medical associations are free to contribute to BAYPAC -- but only to its educational, not political, activities.

(7) WILL BAYPAC's EDUCATIONAL AND POLITICAL ACTIVITIES DUPLICATE, OR WORK AT CROSS PURPOSES WITH THE ACTIVITIES OF SIMILARLY ORIENTED POLITICAL ACTION ORGANIZATIONS?

No. As a state organization, BAYPAC will supplement -- not supplant -- the programs now being carried out by such organizations. BAYPAC, by providing a means through which physicians can concentrate their material resources in an effective manner, will therefore prevent duplication of effort within the profession while strengthening action programs presently in effect. BAYPAC's members should remain active in the political party of their choice. BAYPAC simply furnishes the means whereby they can increase their political effectiveness substantially through combined effort.

(8) HOW WILL BAYPAC USE ITS FINANCIAL RESOURCES TO BEST EFFECT?

In three ways. First, through education. Depending upon the funds available, BAYPAC will develop and promote such programs as: analyses of voting records; reviews of national legislative issues; voter registration drives; and publication of related materials and information.

Second, BAYPAC will follow proved patterns of campaign activity. Selection of target areas will be based upon thorough analysis at the local level, review of reliable national analyses, the marginal nature of the specific district, and other pertinent factors. Support for candidates will be based upon realistic political appraisal.

Third, BAYPAC will coordinate its efforts with the efforts of those individuals and groups -- medical and non-medical -- who are actively engaged in programs designed to obtain good government.

(9) WILL BAYPAC's MEMBERSHIP BE LARGE ENOUGH TO INSURE THAT THIS WILL BE AN EFFECTIVE POLITICAL ACTION GROUP?

Yes. BAYPAC's potential membership is numerically substantial. But this is not the important thing, for numbers are an inadequate yardstick for measuring political effectiveness (except on election day). Remember that elections can be won or lost by relatively few votes. In the 1960 Presidential election, neither candidate received a majority vote. Although nearly sixty-nine million voters went to the polls in 166,256 precincts throughout the United States, victory was won by a hair-line margin of 112,881 -- less than one vote per precinct.

(10) HOW CAN YOU AND THE MEMBERS OF YOUR FAMILY JOIN BAYPAC?

Membership is available by direct application to BAYPAC. Since this is designed to be a permanent program, you may expect to be contacted each year relative to annual dues.

BAYPAC membership dues are $20, which include membership ($10) in AMPAC (American Medical Political Action Committee).

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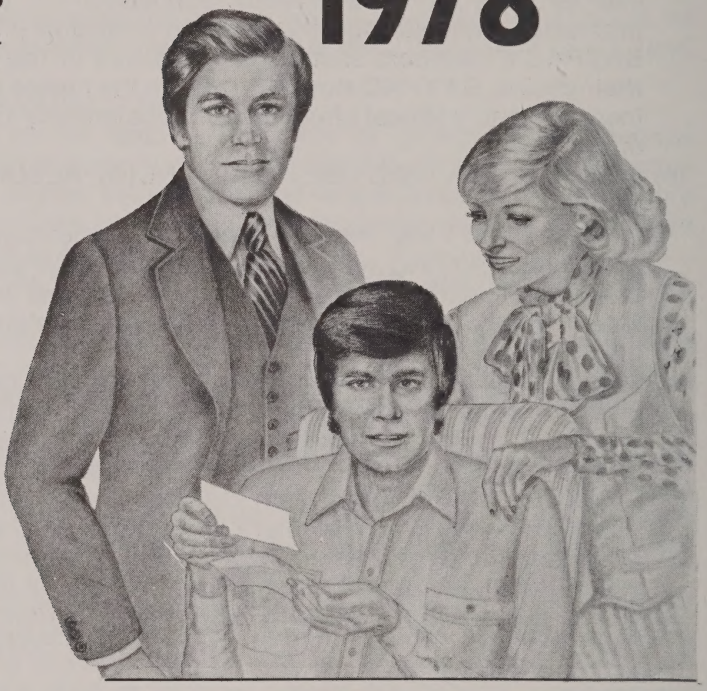

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EXECUTIVE COMMITTEE

The Executive Committee met on Tuesday, December 20, 1977 in the Conference Room of the HDMS. Present were Drs. Verrilli, Walthall, Remsberg, Stoddard, Flahive, Lynn, Magill, Fitzpatrick, Dasco, Abrams and Mrs. Purdy.

Mr. Thomas L. Huston, Vice President Benefits Adminstration and Blue Cross Medical West Project Director was present to inform the committee about the establishing of an HMO at Medical West in Chicopee. Mr. Huston gave a complete picture of the projected HMO and answered questions to the committee. A write up for the membership will be sent in the next Newsletter.

Mr. James Murray from the City Council sent a report for consideration about the concept of de-institutionalization for residents of facilities operated by the Department of Mental Health. Since the Mental Health Committee was disbanded several years ago the committee decided that a new Ad Hoc Committee on Mental Health be formed to work with the City Council on the project. A Chairman will be chosen and a committee formed.

The WMHPC sent in Certificate of Need Applications for various Nursing Homes in the Southern Valley for upgrading Levels of Care and certain additions. The Committee approved these needs and will inform the WMHPC.

Dr. Verrilli gave a report of the hearings held at Winchester Square Community Health Center on the Proposed Health Systems Plan for Western Massachusetts. There was no time for the physicians to present their statements. Therefore, written ones will be sent to the council.

Only two hospitals have answered the letters sent asking for budget and costs of certain procedures for the Ad Hoc Committee on Health Costs. The hospitals will be contacted again as a person in the Health Economic Field from the University of Massachusetts will review these budgets using computer techniques.

The Ad Hoc Committee on Nutrition on the state level is preparing a statement about Obesity Clinics which will be released soon.

Dr. LaMarche, Alternate Nominating Councilor sent in his resignation as Councilor. The Committee accepted this resignation with regrets.

Dr. Hough was appointed to serve as Alternate Nominating Councilor.

A replacement for the Council will be named soon.

The Executive Committee meeting for January has been changed to the 24th.

Mrs. Purdy gave the office report.

The meeting was adjourned at 9:35 P.M. □

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A VIEW POINT:

TO CONTAIN THE COST OF HEALTH

BY
PETER G. SELLEI, M.D.
CHAIRMAN, AD HOC COMMITTEE ON COST CONTAINMENT

On October 26, 1977, the first meeting of the Hampden District Medical Society's Ad Hoc Committee on Health Cost Containment was held. This is, perhaps, the first time that practicing physicians strayed from the beaten paths of concern with the quality of medical care alone and began to come to grips with the cost of that care.

It was high time for this to happen, for we have an enormous stake in bringing cost under control. This is so because, reightly or wrongly we are blamed for the nation's hugh health bill. Indeed, it is estimated that the physician is responsible for 70-90% of all health cost directly or indirectly --- treatments, tests, hospitalization, etc. ordered. Public efforts in other countries to contain cost invariably victimized physicians without attaining their goals.

Public dissatisfaction with the rising cost of health care is manifested by voices as disparate as Ralph Nader, "Forbes" magazine, the management of General Motors Corporation, and closer to home, the Commonwealth government's "White Paper" and Mr. Putnam's

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somewhat misguided fulminations. Scholarly interest in the subject is also rising as evidence by the plethora of articles written on almost every facet of medical care. The voice that is lacking in the cacophony is that of the physician. A pity, because even such unsympathetic viewers as Barbara and John Ehreureich in their book "The Health Empire" regard the physician as a more or less unwitting stooge of what they call the "medical - industrial complex". Their thesis is that technological advances have shifted the center of gravity of most medical practices to the hospital. Big industry encourages the developement of large hospitals because only those, especially the teaching hospitals can afford their latest and most expensive gadgets. Trustees, administrators and physicians at the top of the full-time hierarchy are scrambling for more grants, larger departments, more power, and more prestige. Those getting the "bum rap" are the private, community based physicians, whose independence is being eroded, and the patients. The latter become hardly more than a remote source of income and the substratum for manifold research and pilot projects and other academic endeavors. A rather simplistic picture but not without a kernel of truth.

We are thus adjudged as being both powerless in and responsible for generating most of the demand for health services. What can we do? First of all we must know the cost of what we order and then order judiciously. We must begin to think in terms of cost effectiveness and try to keep cost in proportion to the extra benefit derived through more expenditure.

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We must swallow our civic pride. Just because "all comparable metropolitan areas" have a program, it still may not be necessary for us to acquire one too. A cardiac surgery program springs to mind. Can 50-100 cases a year justify the presence of two full time surgeons, a full time cardiologist and two anesthesiologists as well as the regular infrastructure associated with this endeavor?

We must contain our reflex enthusiasm for teaching, especially if teaching programs generate 60% more laboratory tests and add at least 21% to per diem cost. Prolonged surgery is measured in $100 bills for every extra half hour or fraction thereof spent in the operating room as well as increased morbidity with its attendant cost, more hospital days, more tests, and more drugs. In an age when most experts predict a glut of physicians in general and surgeons in particular, it may not be the best idea to try to stimulate the Massachusetts General Hospital and involve in the process three fourths of the available hospital beds in the community. We most convince ourselves that one need not be associated with a teaching program to practice good medicine. We must be able to sever the umbilical cord and practice our specialties in the real world as well as possible and with as few superfluous refinements as possible. Call it Volkswagen or "paperback" medicine; it makes sense.

We must bring the proliferation of full-time positions under control. All physicians who come into the community must validate their presence in the marketplace. Full-time physicians are not sanctioned by economic forces and their presence is subsidized often by the patients of private practitioners. It seems plausible that full-time men generate more consultations by being more specialized and referring to each

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other. Since their services are reimbursed at a higher level by the "Blues" and Medicaid they represent an inflationary force. This does not mean that full-time men have no place. Any medical community needs a "conscience", someone who is not hurried by the pressures of time and overhead and who sets standards. We must learn to live with the dichotomy between full-time and private men. Nevertheless, the place of full-time men must be adequately and specifically defined.

Since we have reached the limits at what resources the public is willing to commit to medical care, we must set priorities in public. The public is paying for this care through taxes, premiums, and the role of private charity and endowments has shrunk to an insignificant proportion. The time for the benevolent "dictatorship" of trustees and administrators is gone. Decisions affecting health care in a community should not be made at cocktail parties and in "smokefilled rooms". The cost of the decisions ought to be understood by those who pay for them. The hospitals must have a line by line budget showing what activities are self supporting and which are the ones being subsidized. The subsidized activities ought to be subject to public debate. If the community decides it does not want to pay for some, they should be payed for by those who use them. The Hampden District Medical Society could discharge its duty to the community by voicing its informed opinions and help the public make correct decisions. I say "Amen" to the part of the report of the Western Massachusetts Health Planning Council calling for "development of rates provided....(to) eliminate cross subsidation of patients in one category with revenues from charges to patients in other categories."

Finally, we must learn to work with interested representatives of the public, such as the Western Massachusetts Health Planning Council. Having talked to some of their respresentatives and read their "Report on Halth Care Costs and Expenditures", I feel our aims are quite compatible. There is ample scope for exchanging information and ideas and together we may become an effective force for checking the tide of health expenditures not by wrecking the system but by eliminating waste.

It seems fit to conclude with the words of Dr. Dunlop of the University of Mass. "(Physicians must become as concerned with the cost of medical care as they have traditionally been concerned with its quality...particularly if they wish to maintain an effective voice in this area of concern."

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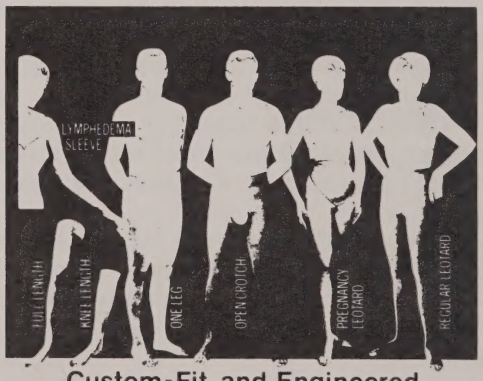
THUNDER ON THE MOUNTAIN

Television station WWLP, by and large, does an excellent job covering and televising local news. Unfortunately WWLP, the initials representing Mr. William L. Putnam, Chairman of the Board of the station, and its sole editorialist, frequently exhibits standards abysmally lower than those of the other members of his highly competent staff.

If his spoken diatribes can be taken in evidence, Mr. Putnam has very little use for physicians. This attitude is not only his right, it puts him in distinguished company which includes all chiropractors, all cancer quacks -- such as laetrile peddlars -- most food faddists, and a considerable segment of the healthy members of the United States Congress.

Historically, for centuries the image of the physician has alternated between that of a hero and a bum. Currently he is a bum and will continue to be for the foreseeable future. In the past his denigrated reputation has been because his therapies were impotent in the face of serious and often fatal disease, or perhaps were too violent for the occasion. Now he is blamed for the high cost of medical care, including hospital care, despite, simplistic though it may appear, the most inflationary force in the entire world is the United States Government, with its prodigious debt, enormous borrowing and spending powers, overwhelming taxes, delirious pension plans for government officials and employees, minimum wage legislation, and especially, as far as medical care is concerned, the enactment over a decade ago of Medicare and Medicaid which increased the demand far in excess of the supply.



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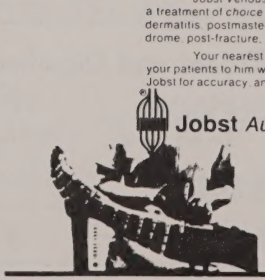

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But we are getting afield. Mr. Putnam on November 29, 30, and December 3 zeroed in, not on the medical profession as a whole, but on one of our members, and not just another member. Dr. John C. Ayres is a former president of the Massachusetts Medical Society and for the past nineteen years of the twenty-five years Commissioner of Health of the City of Springfield. Mr. Putnam, relying on his vast expertise in the field of Public Health takes issue with Dr. Ayres on a matter regarding the serving of food outdoors in downtown Springfield.

There is a truism among physicians who devote their lives to protecting the community from disease that the triumphs in public health are the epidemics that did not occur. This is a concept that obviously would have no appeal to any journalist, either ink or air. There is no such thing as a story about an event that never occurred. We would never expect a subtlety of this magnitude to be comprehended by Mr. Putnam, but we might expect that he could have avoided the consummate cleverness of describing a dedicated and distinguished public servant as "Dr. Neanderthal".

We have never thought of Mr. Putnam as a racist, and doubtless the tiny number of Neanderthalers in this community represent such an insignificant minority that any protest on their part would be audible in conflict with the reverberations thundering down from Provin Mountain preceding the inevitable shrug and smirk that invariable terminate his profundities.

Mr. Putnam has a perfect right to say what he pleases in contradiction to Dr. Ayres about eating dirty food in downtown Springfield, and we will defend to his death his right to say it. □

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HAMPDEN DISTRICT MEDICAL SOCIETY
announces
District Meeting Of Members

DATE: Tuesday, February 7, 1978

PLACE: Storrowton Tavern, Stagecoach Barn
West Springfield, Massachusetts

BUSINESS MEETING: 6:30 P.M.

SOCIAL HOUR: 7:00 P.M.

DINNER: 7:30 P.M.

SYMPOSIUM: "The Impaired Physician"

MODERATOR: Aron M. Leavitt, M.D.
Chairman, Peer Review Committee
H.D.M.S.

SPEAKERS: Mr. E.M. Steindler, Director
Department of Mental Health, A.M.A.

Norman Paul, M.D., Chairman
Mental Health Committee, M.M.S.

Milton M. Parker, M.D., Chairman
Mental Health Committee
Ohio State Medical Association

Dr. Parker will discuss "The Ohio Plan For Disabled Physicians"

. . . . . .

Wives are invited to attend this very special meeting. Dinner for members of HDMS are courtesy of HDMS. The cost for wives is $8.00. Please remit checks with reservations.
If you must cancel your dinner reservations, call the office before noon on February 7, 1978. If cancellations are not made you will be billed for your dinner. □

MEDICAL EDUCATION MEDICAL RIP-OFF

Doctors - we are being ripped off, not so much by the public, maybe a little bit more by the press, but unquestionably and most certainly by our peers. The rip-off is in the concept of continuing medical education which has become a big business in our medical society. Look across your desk, look at the folders, then look at the names of the participants. They do get repetitious. More often than not, it is the same traveling show. The same members going from city to city, just like the old medicine show, with the same message; going from city to city, charging exorbitant prices and saying the same thing. Then, look at the price. If we, in this area of Springfield, can put on a day seminar with 4-5 out-of-town speakers and include a lunch and a cocktail party for $40 (Department of Obstetrics, Baystate Medical Center, take a bow) how in God's name do these societies have the audacity to charge $200-$400 tuition and registration for a 2-3 day meeting and do this with a straight face. What hurts even more is that many of these overpriced "circuses" are sponsored by our own college, in my case, the American College of Obstetrics and Gynecology, for which our annual dues should at least subsidize our continuing education into a reasonably priced meeting.

This emphasis on continuing medical education has also spawned another rip-off master - the deductible vacation. If we go to a meeting in some far off paradise island and attend the sessions from 9-12, then they feel that they can charge exorbitant registration fees, get us the top price of accommodation and transportation, use this extra money to pay some well-known professor or well-known name, so that the whole deal has an aura of prestige, and then call it medical education. I can't quarrel with anybody who wants a vacation, but we need this type of meeting so that the Internal Revenue Service can breath down our back like we need Melvin Belli to sit in on our peer review audits.

What about the context of the meetings? What we, the practitioners, are looking for is help in coping with familiar problems. All too often, the meetings are conceived with extending the frontiers of knowledge and not really dealing with our day-to-day practice. We know, for instance, that a patient when first seen with a vaginal discharge should have a full physical exam and a full history, but it is impossible for us, the practitioner, to do this with every patient. So, why can't they teach what we can omit. In essence, teach us what we came to hear about. Teach us what interests us, not what interests them. Then, why can't they be realistic and come to our world. Our patients can't afford $200 worth of esoteric tests. We don't x-ray every patient that

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comes in with an abdominal cramp or get a glucose tolerance test on every vaginitis. We have to be realistic. Why can't the meeting be realistic?

I think the coup de grace of continuing medical education is the pressures that are forcing us into recertification. There is no doubt in my mind that if our societies continue to place such heavy emphasis on recertification as opposed to self-assessment, then our able legislators will soon legislate recertification-mandatory without a doubt and unfortunately competence and recertification are not synonymous. Responsible physicians are usually constantly aware of the need for self-assessment. Unfortunately, those physicians who are not aware of this need are the physicians that we are not reaching, and those physicians who are aware of the need for self-improvement lose much valuable time from their home and family and their patients in succumbing to the pressures for recertification. Perhaps the biggest crime of all is the cost of recertification. In my particular college, the American College of Obstetrics and Gynecology, we must pay $200 to file for the exam and then $200 to write the exam. Take about 10,000 obstetricians and multiply that by $400. That's a lot of money for a society who claims they are a non-profit organization, only interested in furthering our education. Is this the insult that is finally making us come to our senses - which may be just the education we need.

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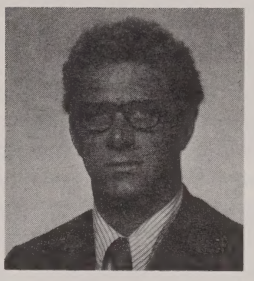
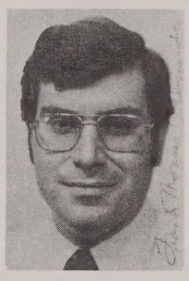
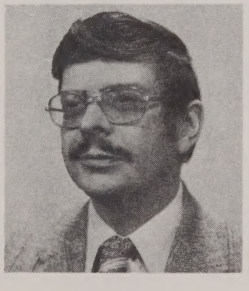


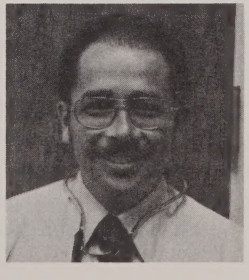
Thomas E. Clarke, M.D., 80 Congress St., Springfield,Mass. 01104 Born: May 12, 1944. Medical School: Harvard - 1970. Internship: University of California at San Francisco, 1970-1971 Surgery, University of California at San Francisco, 1971-1972 Orthopedics, Dartmouth Affiliated Hospitals, 1972-1974 Childrens Orthopedics, Newington Childrens Hospital, 1974-1975. Specialty: Orthopedic Surgery.



Frank T. D'Alessandro, M.D., 77 Boylston St., Springfield, Mass. 01104. Born: April 13, 1947. Medical School: University of Louisville - 1971. Internship: Nassau County Medical Center, East Meadow, New York, July 1971 - June 1972 Department of Anesthesiology, University of Virginia Hospital Charlottesville, Virginia, August 1972 - July 1975. Specialty: Anesthesiology.

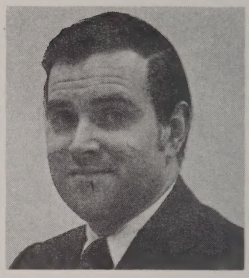


Ronald C. DeConti, M.D., Baystate Medical Center, 759 Chestnut St., Springfield, Mass. 01107. Born: November 8, 1933.Medical School: Yale University School of Medicine - 1959. Internship: North Carolina Memorial Hospital, 1959 - 1960. Residency: North Carolina Memorial Hospital, 1962 - 1964. Specialty: Oncology.

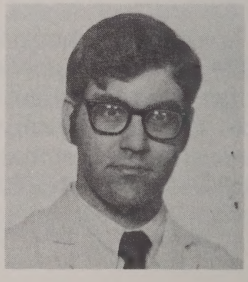


Daniel Dress, M.D., 140 High St., Springfield, Mass. 01105. Born: May 5, 1948. Medical School: Boston University - 1974. Internship: Jacksonville Hospitals Education Program Jacksonville, Floriday, July 1974 - June 1975. Residency: Jacksonville Hospitals Education Program - July 1975 - June 1976, July 1976 - June 1977. Specialty: Emergency Medicine.

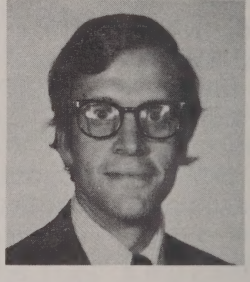
Richard Engelman, M.D., Baystate Medical Center, 759 Chestnut St., Springfield, Mass. 01107. Born: October 18, 1938. Medical School: State University of New York, Downstate Medical Center - 1963. Internship: Straight Surgical Internship, Yale-New Haven Medical Center, July 1963 - June 1964. Residency: Surgical Residency: Yale-New Haven Medical Center, July 1965 - June 1966; George Washington University Hospital Combined Surgical Program, July 1966 - June 1968 Thoracic Surgical Residency New York University Hospital Medical center, July 1968 - June 1970. Specialty: Cardiac Surgery.



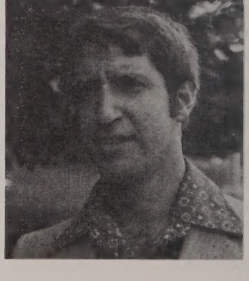
Bruce D. Fisher, M.D., 125 Liberty St., Springfield, Mass. 01103. Born: February 23, 1945. Medical School: Washington University - 1970. Internship: S.U.N.Y. Kings County Hospital Center, Brooklyn, N.Y., July 1970 - June 1971. Residency: N.Y. Hospital, July 1974 - June 1975. University of Minnesota Hospitals, Minneapolis, July 1974 - June 1975. Memorial Sloankettering Cancer Center, N.Y., July 1975 - June 1977. Specialty: Internal Medicine - Infectious Diseases.



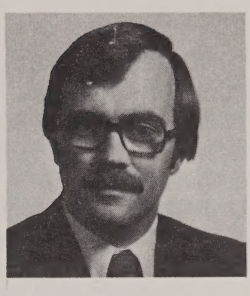
Stephen V. Hall, M.D., 77 Boylston St., Springfield, Mass. 01104. Born: December 30, 1943. Medical School: Harvard Medical School - 1969. Internship: Beth Israel Hospital, Boston, Ma. - June 1969 - July 1970 (Surgery) Residency: Beth Israel Hospital - July 1970 - July 1973 (Anesthesia). Specialty: Anesthesia.



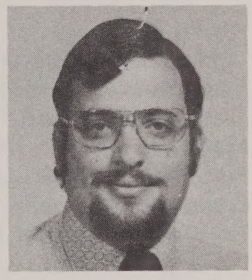
Robert P. Hoffman, M.D., 110 Maple St., Springfield, Mass. 01103. Born: December 10, 1945. Medical School: Albany Medical College - 1970. Internship: Albany Medical Center Hospital - 1970 - 1971. Residency: Albany Medical Center Hospital - 1971 - 1973. Specialty: Internal Medicine.



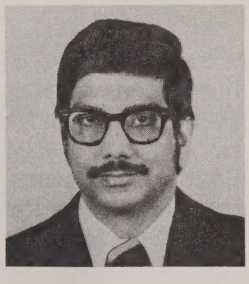
Richard M. Kane, M.D., 48 Court St., Westfield, Mass. 01085. Born: April 20, 1946. Medical School: Medical College of Wisconsin - 1972. Internship: University of South Florida, Tampa, Florida - 1972 - 1973. Residency: University of South Florida - 1973 - 1977. Specialty: Orthopedic Surgery.



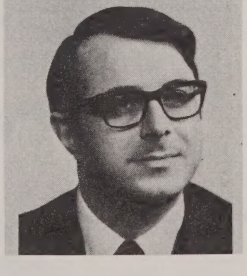
Peter M. Levine, M.D., 110 Maple St., Springfield, Mass. 01103. Born: January 30, 1949. Medical School: Tufts University School of Medicine - 1974. Internship: St. Elizabeth's Hospital, Boston, Ma. - July 1974 - June 1976. Residency: St. Elizabeth's Hospital - July 1975 - June 1976. Specialty: Internal Medicine.



Dipankar Mukherjee, M.D., 476 Appleton St., Holyoke, Mass. 01040. Born: June 19, 1943. Medical School: N.R.S. Medical College - 1966. Internship: St. Louis City Hospital - 1967 - 1968. Residency: Homer G. Phillips Hospital, St. Louis, Mo. (General Surgery) 1968-1972 General Surgery.



John F. Rampone, M.D., 759 Chestnut St., Springfield, Mass. 01107. Born: June 24, 1939. Medical School: Medical College of Wisconsin - 1965. Internship: Rhode Island Hospital - 1965 - 1966. Residency: Johns Hopkins Hospital - 1965 - 1966. Specialty: Gynecology.



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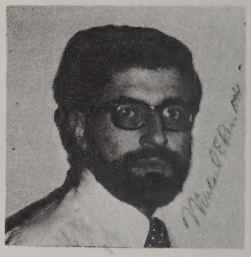
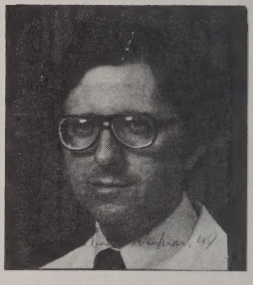
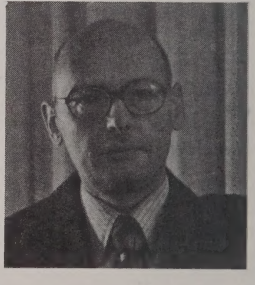


Herbert Sumner Waxman, M.D., 759 Chestnut St., Springfield, Mass. 01107. Born: September 1, 1936. Medical School: Harvard - 1962. Internship: Mass. General Hospital - 1962 - 1963. Residency: Mass. General Hospital - 1963 - 1964. 1966 - 1967. Specialty: Internal Medicine - Hematology.



Peter Zinger, M.D., 15 High St., Springfield, Mass. 01105. Born: September 9, 1929. Medical School: Faculty of Medicine, Charles University, Prague - 1952. Internship: Baystate Medical Center - 1975 - 1976. Residency: Baystate Medical Center - 1976 - 1977. Specialty: Primary Care.



WELCOME TRANSFER!

Richard E. Kauff, M.D., Monson State Hospital, Palmer, Mass. Born: December 30, 1935. Medical School: New York University - 1961. Internship: Bellevue Hospital Centre. Residency: Chief Residency (pediatrics). University of Washington, Seattle, Washington. Specialty: Pediatrics.

THIS'LL GILL YOU

What's Life Like under the sea? Is it a dogfish-eat world? Is everybody united for a common porpoise, or do they all split off into special groupers? One tragic story indicates it's pretty bad down there:

There was once a brilliant sturgeon on the staff of the community health fishility. He was, in fact, one of its flounders. Wiser than Salmon, a fin fellow who would never shrimp from his responsibilities, he was successful and happy; he always whistled a happy tuna. One day, one of his patients, a mere whipper snapper, told the sturgeon that his medical theories were full of abalone, and started trouting around telling everybody that the sturgeon's treatments had made him more eel than he had been, and then actually conched him with a malpractice suit!

Well, the sturgeon was in a real pickerel. The board demanded his oyster, and chased him off the staff. But the case smelt to high heaven, so the judge denied the plaintiff's clam. The board tried to hire the sturgeon back, but by then he had hit the bottlenose, pretty hard, and the end of our shad tail is that the sturgeon wound up on Squid Roe. Buoy! Isn't that a fine kettle of you-know-what?

James Thom in Nuggets

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CORRESPONDENCE

To The Editor :

When I heard from Mrs. Purdy that the "Hampden Hippocrat" was devoting an issue to cost containment, I thought it might be helpful to offer some comments on the Report of the National Commission on the Cost of Medical Care, a summary of which appeared in the December 5 issue of "American Medical News".

The first thing to note is the composition of the Commission. It is broad-based with a large variety of disciplines represented including physicians, labor, government, industry, insurance, hospitals, and legislators - both state and federal. To have a group as varied as this arrive at any conclusion at all is indeed an accomplishment.

Secondly - please note that only a summary is presented with its forty-eight recommendations. These recommendations were arrived at on the basis of a 51% vote of the commissioners and obviously could not please everyone. The privilege of dissent was allowed and any dissenting opinions will be included in the fiscal 3 volume report. Also in the final volumes will be the reports of the force task forces - supply, demand, the market place, and technology - as well as the presentations we heard in plenary session, references and data bases. It is the information in the as yet published material that is most helpful in demonstrating how these recommendations were arrived at.

Finally, read the recommendations carefully - even word by word - and do not make the error of taking things out of context and arriving at a conclusion that is not quite accurate. Already the press has done precisely this in some instances.

To be sure, the report will be controversial and that is probably a plus factor - for real differences of opinion lead to deeper thought processes and perhaps some solutions to the spiraling cost of medical care.

I personally do not fully agree with all the recommendations, but I accept the majority vote and I can assure you I felt greatly privileged to spend 18 months working with such a fine, devoted and thoughtful group of people.

DONALD R. HAYES, M.D.

P.S. A note of congratulations to the "new" Hippocrat. I look forward to each issue way up here in New London, New Hampshire.

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NO BUCK PASSING!

To The Editor:

Periodically and particularly during the so-called vacation seasons, patients are being referred to the Commissioner of Public Health of Springfield for the making out of death certificate on patients in the City of Springfield who have died while their personal physician was out of town. Usually the first approach is to the Medical Examiner, who, when he feels the case is not within his province, declines to accept the responsibility. Then the approach is made to the Commissioner of Public Health. The latter approach is based on a statement on the back of the Standard Certificate of Death of the Commonwealth of Massachusetts, which comes under Rules of Practice:

(1) Attending physicians will certify to such deaths only as those of persons to whom they have given bedside care during a last illness from disease unrelated to any form of injury.

(2) Board of Health physicians will certify to such deaths only as those of persons, who, though disabled by recognized disease unrelated to any form of injury, have died without recent medical attendance or whose physician is absent from home when the certificate of death is needed.

Although these general rules are very succinct in their statements, it must be recognized that attending physicians have certain obligations which they cannot slough off on to some public official for their own comfort and convenience. Should an attending physician find himself in the position that he expects to be out-of-town for a period of time, then it first behooves him to arrange for some other physician to take care of his patients during this period of time. Secondly, the covering physician assumes completely the responsibilities of the attending physician during this period of time when the primary physician is unavailable. Otherwise, there exists a situation tantamount to the abandonment of a patient.

In the instance of a death of a patient, the pronouncement of death is a diagnostic procedure and therefore is considered the practice of medicine. Inasmuch as a covering physician assumes the responsibilities of the original attending physician, then it behooves the former to make the diagnosis and sign the death certificate.

The intent of the rule (2) as quoted above is to take care of emergency situations where there is no possibility of obtaining a death certificate, and it is urgent to dispose of the body properly. The intent certainly is not to grant automatic "carte blanche" coverage to any attending physician to go out of town at any time with the expectation that a Board of Health physician will cover him in any instance of death to one of his patients. Moreover, the intent of the rule is not to grant automatic absolution of responsibility to the covering physician for the care, pronouncement of death, and signing of a death certificate.

A covering physician who is unwilling to accept the responsibilities of the attending physician in absentia could be considered culpable of a breech of medical ethics. □

Sincerely yours,

JOHN C. AYRES, M.D.
COMMISSIONER OF PUBLIC HEALTH

To The Editor:

The recent abuse directed at the staff of Wesson Women's Hospital by anti-abortion groups should not be allowed to influence the humane policies of the hospital administration relating to abortion.

In spite of the noise and the petition sheets, these people do NOT represent the majority thinking, however significant numbers may be in this circumstance. Where the future health and wellbeing of a miserably pregnant woman is in the balance, I support the principle "Any man more right than his neighbors, constitutes a majority of one".

Yet, inasmuch as the self-appointed guardians of our morality are using the number of signatures on an anti-abortion petition to play the numbers game, the November 21st issue of TIME magazine carries a revealing survey by its regular polling organization, Yankelovich, Skelly and White.

In answer to the question "Is it morally wrong to have an abortion?", 48% of those surveyed answered it is NOT wrong, while 44% say it is wrong. Still more significant to the question of responding to pickets, a substantially - larger majority of 64% believe a woman should be legally free to have an abortion if she wants one (interestingly, 58% of Catholics think so, too!)

Long before the Supreme Court recognized the legality of abortion, sympathetic physicians were gambling careers, by freeing the poor, the ignorant, or just vulnerable women of the burder of an unwanted pregnancy. Some were "caught" and suffered the wrath of their Puritanical neighbors. How much better today's more enlightened climate, where those whose beliefs oppose abortion are not obliged to have one, nor to participate in one. And on the other side of the coin, those who believe that abortion, sad as it is, is a better solution in some cases than bringing a child into a world where there is no love, and too often no father.

I have no quarrel with anyone who refuses to have an abortion, or to participate in one. But I oppose in strongest possible terms the efforts of such people to impose their religious or moral beliefs in such a personal matter upon those who believe otherwise. They call it "murder", and use this as their banner, as the Crusaders used "Deus Volt" - "God wills it", to justify their campaigns against "unbelievers" (whom they then proceeded to slaughter, pillaging their cities).

I urge the medical profession to stand strong in support of the right of a woman to make her own decision, free of the intrusion of government and church.

Yours for a better world,
CHARLES F. DEBARGER

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AUXILIARY NEWS

A gentle, swirling snowfall created a silvery setting for the Holiday Tea and Boutique on December 6 at Cynthia Bye's lovely home. Past presidents poured from glistening silver services which were framed by elegant canapes which were prepared by our social chairman Elsie Caldarola, assisted by Francoise Pelletier and Wenda Restall.

Dee Gainski superbly handled the lucrative Bake Sale. Diana Abbasy and Kathy Gray displayed the sold distinctive crafts. Louise Zadworny, assisted by Joanne Janovsky, sold jewelry and items available from AMA-ERF. It was a lovely event which benefited our Scholarship Fund. □

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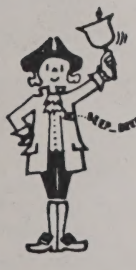

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